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No. 93-510

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

AETNA LIFE INSURANCE COMPANY and
AETNA HEALTH MANAGEMENT,

Petitioners,

—v.—

STUART CIRCLE HOSPITAL CORPORATION,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

MOTION OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC. FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE IN SUPPORT OF PETITIONERS

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Pursuant to Rule 37.2 of the Rules of this Court, *amicus*, the Group Health Association of America, Inc. ("GHAA") hereby moves for leave to file the attached brief *amicus curiae*. Petitioners have granted but respondent has refused to grant consent for GHAA to file a brief *amicus curiae* in support of the petition.

GHAA and its member companies have been active participants in efforts to convince the legislatures of the several States not to enact laws that prohibit or thwart health maintenance organizations (HMOs), preferred provider organizations (PPOs) and similar managed care organizations from contracting with the health care practitioners, facilities and vendors of their choice. These "any willing provider" laws interfere with the

cost-effective delivery of health care services by HMOs and PPOs to their enrolled members. GHAA believes that it is in a position to bring to this Court's attention relevant matters that could be brought fully to the Court's attention by petitioners and that respondent is unlikely to bring to the Court's attention.

In particular, GHAA brings to the Court's attention in the attached brief information which explains that the enactment of "any willing provider" laws by a growing number of States is undermining the concept and structure of managed care as implemented by HMOs and PPOs. More than 30 laws have been enacted in 20 of the States to restrict the ability of HMOs to contract exclusively with the providers of their choice. In 1993, more than 60 any willing provider bills were introduced by the legislatures of 30 States. To date, more than thirteen of these measures in as many States have been enacted this year. GHAA believes that the magnitude of the legislative initiative in the States to enact "any willing provider" laws and the implications this trend may have on health care quality and costs should be fully understood by the Court as it considers whether to grant review of this case.

GHAA therefore respectfully requests leave to file the attached brief *amicus curiae*.

October 29, 1993

Respectfully submitted,

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QUESTION PRESENTED

Did the Court of Appeals err by holding that Virginia's "any willing provider" law regulates insurance and is thus saved from ERISA preemption?

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BRIEF OF GROUP HEALTH ASSOCIATION OF AMERICA, INC. AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, Group Health Association of America, Inc. ("GHAA") files this brief as *amicus curiae* in support of the petition for writ of certiorari.[1]

GHAA, founded in 1959, is the largest and oldest trade association for health maintenance organizations ("HMOs"). Membership in GHAA is open to all prepaid health care organizations that meet GHAA's standards for quality assur-

[1] A motion for leave to file this brief amicus curiae is filed simultaneously with this brief because petitioners have granted but respondent refused to grant consent.

ance, financial solvency, and comprehensiveness of benefits. GHAA's 350 member companies enroll over 30 million people, close to three-quarters of the more than 41.4 million Americans receiving health care coverage through HMOs. GHAA's members include independent locally-based non-profit and for-profit HMOs, HMOs operated by national HMO firms, subsidiaries of Blue Cross and Blue Shield plans, and subsidiaries of major insurance organizations.

HMOs provide or arrange for the provision of health care services to their members. They do so in various ways. Some employ staff physicians. Some contract with individual physicians as independent contractors. Others contract with medical group practices or with associations of individually practicing physicians. Some HMOs may use a combination of those methods. However, all HMOs, through whatever method adopted, provide or arrange for the provision of health care services to members through an established network of selected health care providers. This is in contrast to traditional indemnity health benefit plans, which generally indemnify enrollees for any medically necessary covered health care services without regard to the provider of those services.

HMO have demonstrated success in delivering high quality health care in a cost-effective manner. In 1992, according to a study by A, Foster Higgins, an employee benefits consulting firm, employees paid 23.2% less per employee per year for HMO coverage than for traditional health insurance—$3,313 per employee for HMO coverage versus $4,080 per employee for indemnity coverage. In addition to the lower costs, HMOs offer excellent comprehensive benefits, benefits often not avaliable under traditional indemnity plans. According to GHAA's 1992 national survey of HMOs, virtually all HMOs provided primary care, hospitalization and a variety of preventive services, including well-baby care, prenatal care, well-child care, pap tests, mammography and childhood immunization.

The quality and cost-effectiveness of HMOs has resulted in a tremendous increase in HMO enrollment over the last several years. Total HMO enrollment in 1992 was 41.4 million, more than quadruple the number of enrollees in 1980.

HMOs are one form of what is known as managed care. "Managed care" refers to arrangements that integrate the financing and delivery of health care. The goal of managed care is to promote more cost-effective delivery of health care.

The Virginia law at issue in this case regulates preferred provider organizations ("PPOs"), another form or managed care. Although PPOs differ from HMOs in important respects, they share one very important characteristic—in order to operate effectively, they must selectively contract with a *limited* number of health care providers who agree to provide health care services to plan enrollees according to agreed upon terms and conditions. These terms and conditions include price discounts on health care services.

The Virginia law at issue in this case is commonly referred to as an "any willing provider" law. Such laws restrict the ability of managed care organizations to contract selectively with health care providers by requiring that the managed care organization include in the network any provider willing to meet the terms and conditions established by the managed care organization. The selection of appropriate providers is a key component in creating a cost-effective managed care organization. "Any willing provider" laws severely compromise the ability of a managed care organization to select the providers it wants and greatly undermine the ability of managed care organizations to deliver high quality, cost-effective health care services.

The careful selection of a limited network of providers is essential to the cost-effective operation of an HMO. Selective contracting allows the HMO to negotiate favorable financial arrangements with providers. The HMO can assure the selected providers an increase in patient volume, and guarantee prompt payment, in exchange for the providers' agreement to accept discounted compensation. In essence, selective contracting

encourages providers to compete to provide medical services to HMO members. Only by choosing a *limited* number of providers can the HMO assure the necessary increase in patient volume that will induce and allow the selected providers to offer meaningful price reductions.

It is this competitive dynamic which is destroyed by "any willing provider" laws. By allowing providers to sit back and decide after the fact whether they wish to meet the terms established by the managed care organization, providers have no incentive to compete for inclusion in the network.

The Federal Trade Commission has recognized the procompetitive effect of limited provider networks. *See*, letter from the Acting Director of the FTC's Office of Consumer and Competition Advocacy to the Attorney General of the State of Montana attached as Exhibit E to the Petition for Writ of Certiorari.

Federal courts have also found that limited provider networks are effective in controlling health care costs. For example, among the *findings of fact* in *HCA Health Services* v. *Metropolitan Life Ins. Co.*, 752 F. Supp. 202, 204 (E.D. Va. 1990), a case involving the same statute at issue in this case, were that "[i]t is by limiting the number and types of providers included in a PPO that an insurer is able to implement cost reductions in services for health beneficiaries" and that "[t]he establishment of PPOs has helped to stem the tide of steadily increasing health care costs in this country." The Seventh Circuit Court of Appeals recognized in *Ball Memorial Hosp., Inc.* v. *Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1343 (7th Cir. 1986) that "[t]he requirement that hospitals bid in order to get the plan's business is the principal source of the incentive to cut costs. . . ."

Selective contracting also lowers administrative costs for the managed care organization. When an appropriate number of providers is in the network, the initial contracting costs and the ongoing cost of administration of the network are lower than when a larger and excessive number of providers must be contracted with.

Selective contracting helps to assure the quality of health care provided through the HMO. Selected providers must meet credentialling and other quality assurance requirements in order to participate in HMO provider networks.

Selective contracting ultimately contributes to expand health care consumer choice. Notwithstanding the usual stated rationale for "any willing provider" laws—that they assure that health care consumers will have greater "choice" of providers—"any willing provider" laws actually restrict consumer choice. By undermining the cost efficiencies of PPOs and HMOs, they make it considerably less likely that such arrangements will be made available to health care consumers.

There is already a well-established trend in the States to enact "any willing provider" legislation affecting HMOs. More than 30 such laws in 20 of the States restrict the ability of HMOs to establish or maintain exclusive provider networks. During 1993, more than 60 such proposals were introduced in the legislatures of 30 of the States. Of these proposals, at least 13 in as many States became law. The unabated continuation of this trend will mean that consumers' choice of health plans may ultimately be limited to traditional indemnity plans for health care coverage.

The decision of the Court of Appeals will likely be looked to by other courts presented with the issue of whether a State's "any willing provider" law is preempted by ERISA. GHAA submits this *amicus curiae* brief to highlight the great importance of this case to the ability of HMOs and other managed care organizations to deliver high quality, cost-efficient care.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION

This case represents a critical issue from both a legal and a broader societal perspective. Whether or not the Virginia "any willing provider" law is preempted by ERISA presents this

court with an opportunity to define the scope of ERISA preemption as it relates to a critical feature of an increasing number of employee health benefit plans. From a broader perspective, a decision by this Court on this issue will determine whether ERISA plans will have the flexibility to design plans to take full advantage of an effective tool for controlling health care costs or whether those plans will be subject to unnecessary and burdensome regulation by the States.

II. THE COURT OF APPEALS ERRED IN HOLDING THAT THE VIRGINIA "ANY WILLING PROVIDER" LAW REGULATES THE BUSINESS OF INSURANCE AND IS THUS SAVED FROM ERISA PREEMPTION

The Court of Appeals erred in holding that the Virginia "any willing provider" law is saved from ERISA preemption as a law regulating insurance. This Court has held that only laws that regulate the "business of insurance," as that term of art has been interpreted under the McCarran-Ferguson Act, are saved from preemption. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). This court has also held that selected contracting by a health insurer with health care providers does not constitute the "business of insurance" under the McCarran-Ferguson Act. *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205 (1979). It is therefore impossible to reconcile the Court of Appeals' decision with this Court's precedents. Moreover, the influence that a decision by the Court of Appeals will have on other courts faced with the same issue, combined with the large and growing number of state "any willing provider" laws, will negatively impact the ongoing efforts of managed care organizations to control health care costs.

The fundamental error made by the Court of Appeals was its confusion of the *practice* being regulated—the selection of preferred providers—with the *entity* being regulated—insurance companies. The blurring of this distinction—the very distinction critical to the McCarran-Ferguson analysis—poses a grave

danger to the availability of managed care benefits under employee welfare benefit plans.

The most glaring evidence of the failure of the Court of Appeals to make that crucial distinction is its discussion of the third part of the McCarran-Ferguson analysis. In order for the third prong of the McCarran-Ferguson test to be met, a court must determine "whether the *practice* is limited to entities within the insurance industry." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (emphasis added). The Court of Appeals concluded that "[t]he Virginia statute also satisfies the third criterion. *It* is expressly 'limited to entities within the insurance industry.' " *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 955 F.2d 500, 504 (4th Cir. 1993) (emphasis added). Of course, the "it" referred to by the Court of Appeals is the statute, whereas the "it" that the Court of Appeals should have considered was the *practice* of selecting preferred providers. Thus, the Court of Appeals is saying that because the statute regulates "entities within the insurance industry," *i.e.*, insurance companies, it regulates the "business of insurance." Yet that is precisely the analysis *rejected* by this Court both in *Royal Drug* (holding that provider contracting is not the business of insurance) and in *Pireno*, when it held that *not* every practice engaged in by an insurance company is the business of insurance.

The concern of managed care organizations such as HMOs is that the Court of Appeals' expansion of the concept of the business of insurance will sanction growing regulation by the States of the establishment of uniform managed care benefits under employee welfare benefit plans and thereby undermine the purposes and objectives of ERISA.

Conclusion

The decision of the Court of Appeals is an unwarranted expansion of the insurance saving clause of the ERISA preemption provision. It sanctions the disturbing trend of regulation by the States of managed care provider networks by enactment of "any willing provider" laws. These laws are demonstrably anticompetitive and anticonsumer, and have the effect of raising health care costs. It is critical that this Court review the clearly erroneous decision of the Court of Appeals, which is irreconcilable with this Court's decisions in *Pilot Life*, *Metropolitan Life v. Massachusetts*, and *Royal Drug*, so that managed care organizations can continue to provide high quality, cost-effective care by contracting selectively for the services of appropriate providers of care.

October 29, 1993

Respectfully submitted,

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